STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 92550-001**
v
Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 14th day of October 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 12, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901, *et seq.* The Commissioner reviewed the request and accepted it on August 19, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on August 28, 2008.

The Petitioner's group health care coverage is defined by the BCBSM *Community Blue Group Benefits Certificate* (the certificate). The issue in this external review can be decided by an analysis of this contract. The Commissioner reviews contractual issues pursuant to section 11(7) of the PRIRA, MCL 550.1911(7). This matter does not require a medical review by an independent review organization.

II
FACTUAL BACKGROUND

On February 14, 2008, the Petitioner had coronary artery bypass surgery performed by XXXXX, MD, a nonparticipating provider.

BCBSM paid $3,663.31 of the $7,550.00 charged by Dr. XXXXX. This left the Petitioner responsible for a balance of $3,886.69.

The Petitioner appealed the amount BCBSM paid. BCBSM held a managerial-level conference on June 20, 2008, and issued a final adverse determination dated July 2, 2008. The Petitioner exhausted BCBSM's internal grievance process and seeks review by the Commissioner under PRIRA.

III
ISSUE

Is BCBSM required to pay more for the Petitioner's February 14, 2008, surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that the triple bypass surgery he had on February 14, 2008, was a life and death situation. He says he was told he was lucky to be alive. The Petitioner says the hospital where the surgery was performed decided who the surgeon would be and that he was not aware that Dr. XXXXX did not participate with BCBSM -- the Petitioner just wanted the providers to save his life.

The Petitioner believes that his employer pays for his insurance so that when a situation comes up like the one he had February 14, 2008, it should be covered 100%. The Petitioner does not believe there should not be a dollar amount limit put on someone when a life is at stake.

The Petitioner wants BCBSM to pay the full amount charged for his surgery.

BCBSM's Argument

The Petitioner's coverage provides that BCBSM will pay its approved amount for the Petitioner's February 14, 2008, surgery. However, since the surgeon does not participate with BCBSM, he is not obligated to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between his charge and BCBSM's payment.

BCBSM says it is not obligated to pay more than the approved amount even in emergency situations, or when the patient has no choice of providers, or even if the Petitioner was referred by a participating provider. BCBSM said it paid its full approved amount for the Petitioner's February 14, 2008, surgery -- no deductible or copayment was applied.

BCBSM believes that it correctly paid for the surgical services received by the Petitioner.

Commissioner's Review

The certificate describes how benefits are paid. On page 4.2, the certificate says that BCBSM pays its "approved amount" for physician and other professional services. The approved amount is defined on page 7.2 as "the lower of the billed charge or [BCBSM's] maximum payment level for the covered service."

The following table sets forth the amounts charged by Dr. XXXXX and BCBSM's maximum payment for the procedure, and the amounts actually paid by BCBSM:

Procedure Code	Amount Charged by Surgeon	BCBSM's Maximum Payment	Approved Amount Paid by BCBSM	Balance Due
AS 33518	$250.00	$86.64	$86.64	$163.36
AS 33533	$1,000.00	$445.63	$445.63	$554.37
33518	$1,300.00	$509.65	$509.65	$790.35
33533	$5,000.00	$2,621.39	$2,621.39	$2,378.61
Total	$7,550.00		$3,663.31	$3,886.69

The approved amount is paid to both participating and nonparticipating providers. However, BCBSM's participating providers agree to accept the approved amount as payment in full for their

services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full. Section 4 of the certificate, "How Physician and Other Professional Provider Services Are Paid," explains this (page 4.29):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

It is unfortunate that the Petitioner was unable to use a participating surgeon. Nevertheless, the certificate does not require BCBSM to pay more than its approved amount for services of a nonparticipating provider in such a situation, even if there was no choice of providers or even if the surgery was provided on an emergency basis.

The Commissioner finds that BCBSM has paid the claim correctly according to the terms and conditions of the certificate and is not required to pay more for the services provided to the Petitioner.

V
ORDER

BCBSM's final adverse determination of July 2, 2008, is upheld. BCBSM is not required to pay more for the Petitioner's February 14, 2008, surgery.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Ken Ross
Commissioner